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A well-balanced combination of a clinical text, reference material and multicolor illustrations make this review of nervous system anatomy eminently useful for students and practitioners alike. The new edition includes revised indexes, updated nomenclature, and recent research results.
Muscles of the Eyeball (A-1)

The eyeball is attached to the orbit by the muscles of the eyelids, and it can move in all directions. Movements are achieved by the extraocular muscles, namely, the rectus muscles, and the inferior oblique muscle.

The rectus muscles (A-C) (abducens nerve) act above the eyeball in a slightly oblique, downward direction. The inferior rectus muscle (A-C) (abducens nerve) acts on the eyeball in the same direction as the rectus muscles. At the lateral aspect of the eyeball is the external rectus muscle (A-C) (abducens nerve), which is innervated by the oculomotor nerve (III). The lateral rectus muscle (A-C) (abducens nerve) is the largest muscle of the eye and is responsible for lateral gaze. The superior oblique muscle (C) (abducens nerve) is responsible for upward gaze and depression of the eyeball. The inferior oblique muscle (D) (abducens nerve) acts on the eyeball in the same direction as the rectus muscles, and it is responsible for depression and elevation of the eyeball.

The superior rectus muscle (G) (abducens nerve) is responsible for upward gaze and depression of the eyeball. The inferior rectus muscle (G) (abducens nerve) acts on the eyeball in the same direction as the rectus muscles, and it is responsible for depression and elevation of the eyeball.

Movements of the eyeball:
- Rotation around the vertical axis toward the nose (adduction) and the temple (abduction)
- Rotation around the horizontal axis upward (elevation) and downward (depression)
- Rotation around the sagittal axis with rolling of the upper part of the eyeball toward the nose (toward naso-orbital rotation) and toward the temporal (contralateral rotation)

Clinical Note: Paralysis of individual eye muscles cause facial asymmetry, which is observed in disorders of the extrinsic muscles of the eye, such as hemifacial spasm.
Muscles of the Eyeball (A-E)

The eyeball is attached by a membra neous capsule to the capsule of the orbit for body, and it can move in all directions. Movements are achieved by six extra-eye muscles, namely the rectus muscles and two oblique muscles. The tendons of origin of the rectus muscles form a funnel-shaped ring around the optic canal, the common annular vessels (A1). The superior rectus muscle (A-C) (oculomotor nerve) runs above the eyeball in a slightly oblique, outward direction. The inferior rectus muscle (A-C) (oculomotor nerve) runs beneath the eyeball in the same direction. At the nasal aspect of the eyeball, the lateral rectus muscle (A-C) (abducens nerve) runs beneath and lateral to the rectus muscle (A-C) (abducens nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the lateral rectus muscle (A-C) (abducens nerve) and the rectus muscle (A-C) (abducens nerve) attach at the lateral pole of the eyeball. The superior oblique muscle (A-C) (trochlear nerve) originates medially at the inferolateral aspect of the lateral rectus muscle (A-C) (abducens nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the superior oblique muscle (A-C) (trochlear nerve) attaches on the lateral rectus muscle (A-C) (abducens nerve). The inferior oblique muscle (A-C) (abducens nerve) originates medially at the inferolateral aspect of the lateral rectus muscle (A-C) (abducens nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the inferior oblique muscle (A-C) (abducens nerve) attaches on the lateral rectus muscle (A-C) (abducens nerve).

The posterior rectus muscle (A-C) (oculomotor nerve) runs above the eyeball in a slightly oblique, outward direction. The inferior rectus muscle (A-C) (oculomotor nerve) runs beneath the eyeball in the same direction. At the nasal aspect of the eyeball, the lateral rectus muscle (A-C) (oculomotor nerve) runs beneath and lateral to the rectus muscle (A-C) (oculomotor nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the lateral rectus muscle (A-C) (oculomotor nerve) and the rectus muscle (A-C) (oculomotor nerve) attach at the lateral pole of the eyeball. The superior oblique muscle (A-C) (trochlear nerve) originates medially at the inferolateral aspect of the lateral rectus muscle (A-C) (oculomotor nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the superior oblique muscle (A-C) (trochlear nerve) attaches on the lateral rectus muscle (A-C) (oculomotor nerve). The inferior oblique muscle (A-C) (oculomotor nerve) originates medially at the inferolateral aspect of the lateral rectus muscle (A-C) (oculomotor nerve). At a distance of 0.5-1.0 cm from the margin of the orbit, the inferior oblique muscle (A-C) (oculomotor nerve) attaches on the lateral rectus muscle (A-C) (oculomotor nerve).

Movements of the eyeball:
- Rotation around the vertical axis (adduction) and toward the temporal direction
- Rotation around the horizontal axis upward (elevation) and downward (depression)
- Rotation around the sagittal axis with rolling of the upper half of the eyeball toward the nose (toward rotation, or intorsion)
- Rotation around the sagittal axis with rolling of the lower half of the eyeball toward the temporal direction (away from rotation, or extorsion)

Clinical Note: Paralysis of individual eye muscles causes double vision, when eyes are in the Horizontal plane, the affected eye is deviated outward, and the surrounding eye is deviated inward. The relative position of the two images, which are reflected in the eye, is either more or less than 50% each.
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Frequency of Barrett’s neoplasia after initial negative endoscopy with biopsy: a long-term histopathological follow-up study

M. Vieth1, B. Schubert1, K. Lang-Schwarz1, M. Stolte1
1 Institute of Pathology, Klinikum Bayreuth, Bayreuth, Germany

Background: Barrett’s adenocarcinoma is being diagnosed increasingly. We examine possible differences between long segment and short segment Barrett esophagus (LSBE and SSBE) in long-term follow-up on the basis of our histopathology registry.

Methods and patients: All Barrett’s esophagus patients diagnosed histologically between 1990 and 1996 (n = 1071) were selected. Long-term follow-up data from endoscopy with biopsy were sought on all patients without neoplasia on initial endoscopical biopsy (n = 1003). A total of 225 individuals (25.4%) were regarded as drop-outs (201 lost and 54 without further endoscopy). Of the remaining 748 patients with follow-up for more than 5 years, 315 had documented LSBE, 246 had SSBE, and 187 had no length of Barrett esophagus recorded (NLBE).

Results: In the study cases (male: female ratio 2:1, mean age ± SD 60.9 ± 14.2 years), the biopsy procedure was fully compliant with guidelines in only 32.5%. Only 5 cases (0.6%) had visible lesions reported on endoscopy, but all were negative for neoplasia. Over a mean follow-up of 70.2 ± 35.6 months (range 0–240), 7 new cases of low grade intraepithelial neoplasia (LGIN) and 15 cancer cases developed, accounting for a yearly incidence of 0.2% (LGIN) or 0.4% (cancer) after an initial negative endoscopy. When the cases with initial diagnosis of neoplasia were included, this yearly incidence rose to 0.5% (LGIN), 0.3% (high grade intraepithelial neoplasia [HGIN]) or 1.7% (cancer). Differences between SSBE and LSBE were only encountered for cancer incidence.

Conclusion: The yearly incidence of Barrett esophagus cancer varies between 0.4% and 1.7%. Despite the limitations of this retrospective and pathology-based study, the observed risk of developing cancer in Barrett esophagus without neoplasia is comparable to that found in other studies, mainly from the US and the UK, and varies between 0.7% and 1.0% of yearly incidence.
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